Health Benefit Plans (a.k.a. Major Medical)
Large Employer Group Only

These standards are provided to assist the insurer in filing forms and rates. They are not intended to be all-inclusive, and are a work in progress. The standards are a brief synopsis and do not contain all requirements or exceptions. All citations should be reviewed. ***Insurers are responsible for assuring that forms and rates submitted comply with Utah Insurance Code and Rules, UCA § 31A-21-201(2). If submitted filings are found to be out of compliance they may be referred to our Market Conduct Division for review and possible action.***

Filing Procedures		
Filing Submission	31A-21-201 R590-220	Requirements and processes for submission of forms, rates and related reports. The insurer is responsible for compliance with Utah Code and Rules. A filing that does not comply with code, rules, or standards may be rejected. Rejected filings are not considered filed with the department.
Sample Data	R590-220-7	Each form must be completed with data that is representative of the market intended to accurately reflect its purpose and use.
Variability	R590-220-7	All variable information must be bracketed with an explanation of the variables. Changes must be refilled prior to use.
General Requirements		
Appeal Process	31A-22-629 R590-203	Standards for review of adverse benefit determination.
Application	31A-21-201(3) 31A-21-201(3)(a)(i)	Application must conspicuously provide the exact name of the insurer, and the state of domicile of the insurer. Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition. An application that includes the question of rated, modified, or issued other than as applied for must reference “to your knowledge.”
Arbitration	R590-215	Compulsory binding arbitration or voluntary binding arbitration at the election of the insurer are not permissible. An arbitration provision must be properly disclosed in the policy, certificate, application, and enrollment forms. It may not deprive Utah courts of jurisdiction over an action against an insurer.
Certificate	31A-21-311	Certificate shall contain a summary of the essential features of the insurance coverage, including any rights of conversion. The certificate must conspicuously provide the exact name of the insurer, and the state of domicile of the insurer.
Claim Settlement	31A-26-301.6 R590-192	Provides for fair and rapid settlement of claims and protection of claimants from unfair claims settlement practices. **Interest must be paid when claim is not paid timely.**
Company Name	31A-21-201, 301 & 311	The exact name of the insurer and its state of domicile must appear conspicuously in the policy and application.
Definitions	31A-1-301	Forms must comply with these definitions.
Discretionary Clauses	R590-218	Discretionary clauses in forms that are not associated with ERISA employee benefit plans are prohibited. The rule provides required language that must be included in ERISA employee benefit plans sponsored by employers if the insurer is the claim or plan administrator.
Endorsement or Rider	31A-21-106	A contract may not be modified unless it is in writing and requires a signed acceptance by the insured.
Felony, riot or insurrection	31A-21-201	May exclude losses resulting from an insured’s ***voluntary*** participation in a felony, riot or insurrection, or similar act.
Grace Period	31A-22-607	Policies shall provide a grace period. Group policies must provide a 30 day grace period during which the policy remains in-force.
Grievance	31A-22-629 R590-203	Utah has adopted the federal claims regulations for a grievance review process.
Incontestability	31A-22-609	Only a fraudulent misstatement regarding insurability is a basis for avoidance after coverage has been in effect for two years.
Incorporation by Reference	31A-21-106	Except for federal and state law, regulations or public directive, forms may not contain any agreement or incorporate any provision not fully set forth in the policy, application, or attached documents.
Jurisdiction	31A-21-314	Policy cannot contain any provision requiring it to be construed according to the laws of another jurisdiction, or deny Utah courts jurisdiction.
Limitation of Actions	31A-21-313	Cannot restrict the right of action against an insurer to no less than 60 days and no more than three years from the date

		the cause of action accrues.
Medicare Eligibility	31A-21-201(3)(a)(i) R590-131	Benefits may not be reduced on the basis that an insured is eligible for Medicare, or other government programs. Benefits may be coordinated to the extent benefits are paid.
Nondiscrimination Among Health Care Professionals	31A-22-618	Insurers may not unfairly discriminate against any licensed class of health care providers by structuring contract exclusions that exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice.
Notice of termination	31A-22-716	Every policy shall include a provision that obligates the policyholder to give 30 days prior written notice of termination and to notify of right to continue coverage upon termination.
Physical Exam	31A-21-201	If an insurer requires a physical exam, the insurer must pay for such exam.
Proof of Loss and Notice	31A-21-312 Bulletin 87-6	Proof of loss provision must allow notice and /or proof of loss to be filed as soon as reasonably possible. Proof of loss provisions may not contain a limitation that it applies only when the insured is legally incapacitated.
Return of Premium	31A-21-312	All excess premium payments must be returned upon such finding.
Dependent Coverage		
Administrative or Court Ordered Coverage	31A-22-610.5	Coverage must be provided without regard to the enrollment season, dependency, residence or service area when an administrative or court order exists. The insured, another parent, state agency, or child support enforcement program may enroll the child.
Coverage from the Moment of Birth or Date of Placement	31A-22-610	If the policy provides coverage for any member of a policy or certificate holders family, the policy shall provide coverage for: 1. A newborn child from the moment of birth; and 2. An adopted child, from the moment of birth if placement for adoption occurs within 30 days of the child's birth, or from the date of placement if placement for adoption occurs 30 days or more after the child's birth. Placement for adoption may not be defined more restrictively than the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.
Definition	31A-22-610.5	Dependents must be covered to age 26. Insurers dependency requirement must treat all dependents equally, be the same for all ages, and may not require student status.
Disabled Dependents	31A-22-611	A policy that provides coverage for dependents shall provide coverage for disabled dependents that have been continuously covered under any accident and health insurance coverage since age 26.
Residence	31A-22-718	A child may not be denied on the sole basis that the child does not reside with the insured or because the child is solely dependent on a former spouse of the insured rather than on the insured.
Specific Requirements		
Alcohol & Drug Treatment	31A-22-715	Each group policy shall contain an optional rider allowing for alcohol or drug dependency treatment.
Cancellation, Renewability, and Termination	31A-22-721	Health benefit plan is renewable and continues in force except for stated reasons.
Conversion Rights	31A-22-723	Group conversion rights for those who have been continuously covered for at least six months immediately prior to termination.
Coordination of Benefits	Rule R590-131	Requirements for coordination of benefits provisions.
Creditable Coverage	31A-22-605.1	A carrier shall waive any time period applicable to a pre-existing condition exclusion or limitation period.
Diabetes Coverage	31A-22-626 R590-200	Diabetes coverage including services, supplies, and self-management training.
Emergency Services	31A-22-627	Definition of “Emergency Medical Condition” and coverage requirements.
Inborn Metabolic Errors	31A-22-623 R590-194	Mandated coverage of inborn errors of amino acid or urea cycle metabolism.
Maternity Minimum Stay	31A-22-610.2	May not be limited to less than 48 hours for normal delivery, and 96 hours for caesarean section delivery for both mother & newborn.
Mastectomy Coverage	31A-22-630	Mastectomy coverage must include coverage for reconstruction, prostheses, etc.; continued eligibility must not be

	31A-22-719	prejudiced.
Preexisting Conditions	31A-1-301 31A-22-605.1	A health benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of the enrollment date or the effective date of coverage. A health benefit plan may not deny, exclude, or limit benefits for losses incurred more than 12 months, or 18 months in the case of a late enrollee.
Preferred Provider Provisions	31A-22-617	Non-contracted providers must be reimbursed at the rate of 75% of the average paid contracted providers.
No Rating Requirements		
Reporting Requirements		
Withdrawal from Market	31A-30-107 31A-4-115 Rule R590-199	Prior to withdrawing from the large employer health benefit plan market, a carrier must submit a letter to the commission at least 3 working days prior to notice to the affected insureds.